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COMBINED TRANSMITTAL OF APPEAL BRIEF TO THE BOARD OF PATENT APPEALS AND INTERFERENCES & PETITION FOR EXTENSION OF TIME UNDER 37 C.F.R. 1.136(a) (Small Entity)	Docket No. A-7709

In Re Application Of: **George M. HALOW and Lewis E. ZUNIGA**

Serial No.	Filing Date	Examiner	Group Art Unit
10/042,236	January 11, 2002	A.G. Kalinowski	3626

Invention: **MEDICAL BILLING SYSTEM TO PREVENT FRAUD**

TO THE COMMISSIONER FOR PATENTS:

This is a combined Transmittal of Appeal Brief to the Board of Patent Appeals and Interferences and petition under the provisions of 37 CFR 1.136(a) to extend the period for filing an Appeal Brief.

Applicant(s) hereby request(s) an extension of time of (check desired time period):

☒ One month ☐ Two months ☐ Three months ☐ Four months ☐ Five months

from: **March 14, 2004** (*Date*) until: **April 14, 2004** (*Date*)

The fee for the Appeal Brief and Extension of Time has been calculated as shown below:

Fee for Appeal Brief:	$165.00
Fee for Extension of Time:	$55.00
TOTAL FEE FOR APPEAL BRIEF AND EXTENSION OF TIME:	**$220.00**

The fee for the Appeal Brief and extension of time is to be paid as follows:

☒ A check in the amount of **$220.00** for the Appeal Brief and extension of time is enclosed.

☐ Please charge Deposit Account No. in the amount of

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- ☒ Any additional filing fees required under 37 C.F.R. 1.16.
- ☒ Any patent application processing fees under 37 CFR 1.17.

☒ If an additional extension of time is required, please consider this a petition therefor and charge any additional fees which may be required to Deposit Account No. **08-2455**

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Invention: **MEDICAL BILLING SYSTEM TO PREVENT FRAUD**

TO THE COMMISSIONER FOR PATENTS:

This combined Transmittal of Appeal Brief to the Board of Patent Appeals and Interferences and petition for extension of time under 37 CFR 1.136(a) is respectfully submitted by the undersigned:

Signature

Dated: 4/13/04

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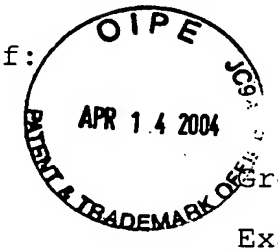


In re the application of:

George M. HALOW and
Lewis E. ZUNIGA

Serial No: **10/042,236**

Group Art Unit: **3626**

Examiner:
Alexander G. Kalinowski

Filed : **January 11, 2002**

For : **MEDICAL BILLING SYSTEM TO PREVENT FRAUD**

APPLICANT'S APPEAL BRIEF UNDER 35 U.S.C. §1.192

Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sir:

By notice of the Appeal filed on January 14, 2004, applicants have appealed the final rejection dated August 15, 2003, and submit this brief in support of that appeal.

(1) REAL PARTY IN INTEREST

The real party in interest are the applicants George M. Halow and Louis E. Zuniga.

(2) RELATED APPEALS AND INTERFERENCES

There are no related appeals and interferences regarding the present application.

(3) STATUS OF CLAIMS

Claim 1 has been rejected.
Claim 2 has been rejected.
Claim 3 has been cancelled.
Claim 4 has been rejected.
Claim 5 has been rejected.

Claim 6 has been rejected.
Claim 7 has been rejected.
Claim 8 has been rejected.
Claim 9 has been rejected.
Claim 10 has been rejected.
Claim 11 has been rejected.
Claim 12 has been rejected.
Claim 13 has been rejected.
Claim 14 has been rejected.
Claim 15 has been rejected.
Claim 16 has been cancelled.
Claim 17 has been rejected.
Claim 18 has been rejected.
Claim 19 has been rejected.
Claim 20 has been rejected.
Claim 21 has been rejected.
Claim 22 has been cancelled.
Claim 23 has been cancelled.

(4) STATUS OF AMENDMENTS

An Amendment was filed on November 17, 2003, responsive to the Final Rejection of August 15, 2003. As indicated by the Advisory Action mailed on December 12, 2003, this Amendment After Final was entered.

(5) SUMMARY OF INVENTION

Applicant's invention is directed to a system and method for eliminating or at least limiting fraud due to improper or deceptive medical claims being submitted from a medical provider. As shown in the drawings, a clearing house 12 is provided for receiving medical claims produced by a medical provider 14. A number of private as well as public insurance agencies 16 are in communication with the clearing house 12. Once a provider 14 submits his or her claim to the insurance companies, this information would also be transmitted to the

clearing house 12. The clearing house would review the medical claim and compare this claim with other claims submitted by that provider. This data is analyzed by the clearing house at step 44 in Figure 2 utilizing a computer system provided with unique software. Once it has been determined that the medical claim is legitimate, the provider would be paid at step 48.

As part of the analyzation process, the clearing house 12 would analyze the particular claim submitted by a single medical provider or practitioner and compare this claim with other claims previously submitted by that medical provider or practitioner. The software utilized by the clearing house would have the ability to determine whether the medical practitioner billed out more treatment hours than was possible (see page 12, paragraph 34). Additionally, if the medical practitioner made a claim for a particular period of time in a first instance and made a subsequent claim for that particular period of time for either the same patient or a different patient, the software, according to the present invention, would deny that second claim (see page 12, paragraph 35). The software would be provided to the clearing house allowing the analysis to take place relating to the total hours billed by a particular medical practitioner during a particular period of time, such as one work day. This software would also be utilized to determine whether the medical practitioner made a subsequent claim for a particular period of time which had already been billed. In both circumstances, the software must compare information provided by the medical practitioner to the clearing house regarding a "new" claim with information previously relayed to the clearing house by the medical practitioner for previous claims.

(6) ISSUES

The issue of this appeal is statutorily formulated in 35 U.S.C. §103. Specifically, the issue is whether the claimed invention recited in claims 1, 2, 4-15 and 17-21 are obvious over U.S. Patent 6,343,271, issued to Peterson in view of U.S. Patent 5,359,509, issued to Little and the article entitled "Clamping

Down on Code Creep" authored by Kenneth Kienle (hereinafter Kienle). This rejection was made specifically for claims 1, 2, 6, 7, 9, 10, 13-15, 19 and 21-23. Claims 4 and 5 as well as 17 and 18 were rejected in view of the above-cited references further in view of U.S. Patent 6,253,186, issued to Pendleton, Jr.

Additionally, an issue arises whether the subject matter added to claims 1 and 13 by the Amendment After Final which was entered by the Examiner was proper based upon the Examiner taking official notice that "...it was well known in the claims fraud detection arts to flag multiple claims submitted by more than one patient at a single period of time on a single day from a provider".

(7) GROUPING OF CLAIMS

The present application includes a single independent system claim 1, and claims 2, 4-12 depending therefrom as well as a single method claim 13, including claims 14, 15 and 17-21 depending therefrom. Claims 1, 2 and 6-12 would stand or fall with independent claim 1. Claims 14, 15 and 19-21 would stand or fall with independent claim 13. Additionally, claims 4, 5, 17 and 18 would stand or fall together.

(8) ARGUMENTS

In the final Office Action mailed on August 15, 2003, the Examiner stated:

> As to claim 1, Peterson discloses a system for reviewing medical treatment claims provided by a plurality of practitioners to a plurality of insurance entities for the determination of the appropriateness of the medical treatment claims (i.e. adjudicating medical insurance claims)(see Abstract), comprising:
>
> a clearing house for receiving information information from the plurality of practitioners regarding claims to be paid by

> one or more of the plurality of insurance entities (i.e. permits healthcare providers to electronically prepare insurance claims and submit claims to the claims processing system)(Col. 6, lines 64-66 and Col. 7, lines 6-9), said clearing house provided with software to determine the appropriateness of each of the claims submitted by each of the plurality of practitioners (i.e. a predefined set of adjudication rules are contained in auto adjudication database and provide criteria by which claims are either proved or denied)(Col. 9, lines 31-35), said clearing house communicating with the plurality of insurance entities and the plurality of practitioners regarding the appropriateness of each of the claims (i.e. health care provider may use the automated adjudication system to determine whether the claim is to be automatically adjudicated or manually adjudicated... health care provider may access information regarding the adjudication status of a submitted claim... claims that require manual claims adjudication are transferred to a claims shop 52 or private contractors employed by insurers 54)(Col. 6, line 64 - Col. 7, line 13 and Col. 9, lines 31-45).

As the Examiner indicated, Peterson does not exclusively disclose "wherein said software determines the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single treatment period of time on a single day". The Examiner went on to say that the patent to Little does disclose software to determine the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single period of time on a single day.

The Examiner went on to cite the Kienle reference for disclosing the appropriateness of each of the claims based upon whether one of the practitioners has submitted more than one disparate treatment claim for a single block of treatment time on a single day.

The Examiner rejected claims 22 (dependent from claim 1) and 23 (dependent from claim 13) based upon the patents to Peterson, Little and the Kienle reference. The Examiner admits that these references do not explicitly disclose a situation in which a single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day. The Examiner went on:

> "However, the Examiner takes official notice that it was well known in the claims fraud detection arts to flag multiple claims submitted for more than one patient at a single period of time on a single day from a provider. The motivation was to flag claims that would be difficult if not impossible for a provider to legitimately perform. It would have been obvious to ne [sic] of ordinary skill in the art at the time of applicant's invention to include wherein the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day within the Peterson and Little method for the motivation above."

The U.S. Supreme Court interpreted the standard for 35 U.S.C. §103 in Graham v. John Deere 383 US1, 148 USPQ 495(1966). In Graham the Court stated that under 35 U.S.C. §103:

> The scope and content of the prior art to be determined; differences between the prior art and the claims that issue are to be ascertained; and the level of ordinary skill in the pertinent art resolved. Against this background, the obviousness or non-obviousness of the subject matter is determined. 148 USPQ 467.

Using the standard set forth in Graham, the scope and content of the prior art relied upon by the Examiner will be determined. Applicant in the Amendment filed June 3, 2003, traversed the rejection of claims 22 and 23 in a rejection mailed on March 26, 2003, based upon the Examiner taking official notice that it is well known in the claims fraud detection arts to flag multiple claims submitted for one patient at a single period of time.

The Final Rejection mailed on August 15, 2003, maintained this rejection utilizing the official notice. Applicant's amendment of November 17, 2003, added the subject matter in claim 22 to claim 1 and in claim 23 to method claim 13. This subject matter recited a system (claim 1) or a method (Claim 13) in which the clearing house made a determination of whether the single practitioner claimed medical treatment for a single block of treatment time on a single day for different patients. This amendment also noted the lack of appropriateness for the official notice utilized by the Examiner.

The Examiner in the Office Action of December 10, 2003, maintained the Final Rejection but did indicate that the amendment would be entered, thereby adding the subject matter in claims 22 and 23 to claims 1 and 13 respectively. This Office Action indicated that the Examiner was not required to provide such a piece of art. However, the Examiner did submit to the applicant a piece of prior art authored by Hartnett-Barry. Although the Examiner did include this new piece of art, the rejection utilizing the official notice was maintained.

The patent to Peterson is directed to a method and apparatus for detecting fraud in a system in which a plurality of practitioners submit claims to a clearing house utilized by a plurality of insurance entities. The main thrust of this patent would allow a medical practitioner to pre-submit a claim for the purpose of having the clearing house indicate whether that claim would be automatically allowed using an auto-adjudication process of would be allowed only after the claim was manually adjudicated. The Examiner admitted that there is nothing in this patent relating to a situation for determining the appropriateness of a claim based upon whether a medical practitioner claims a single treatment time for a single day. Consequently, the Examiner has utilized the Little et al patent for this purpose. As indicated in Col. 7, lines 10-26 of the Little et al patent, the system included therein was directed to the situation in which several surgical procedures were deemed to be consistent with a particular condition. As stated therein, "a review code for multiple (emphasis added) surgical procedures,

for example, could be assigned to each surgical procedure on a payment request having more than one surgical procedure listed for the same day for the same patient." Therefore, it is submitted that the Little et al patent is not directed to the situation which a single block of treatment time would be examined to determine whether a medical practitioner billed for more than one procedure during a single treatment time. There is nothing in this patent as well as the Kienle reference which is directed to a situation in which more than one patient is billed during a single block of time i.e. 15 minutes, 1/2 hour, 1 hour, etc.

As indicated hereinabove, the Examiner took official notice that it is well known in the claims fraud detection arts to flag multiple claims submitted for more than one patient at a single period of time on a single day from a provider. Therefore, the Examiner took the position that it would be obvious to modify the teachings of the Peterson, Little and Kienle references in the manner as recited in claims 22 and 23, now included in claims 1 and 13, respectively, to render obvious a patent claim wherein the clearing house checks to determine whether a medical practitioner in a second claim, already billed an insurance company for a disparate patient in a first claim. It is respectfully submitted that the Examiner was using hindsight and applicant's own disclosure to reach the conclusion that it was legitimate to take official notice of the subject matter initially included in claims 22 and 23. It is believed that official notice should not have been taken for this feature.

On numerous occasions, the issue of official notice or judicial notice have been addressed by the Courts. For example, *In re Ahlert and Kruger*, 165 USPQ 418, 420 (CCPA 1970), specifically stated that "as to the propriety of the Board's taking such notice at all, this Court has already determined that the Patent Office Appellate Tribunals, where it is found necessary, may take notice of facts beyond the record, while not generally notorious, are capable of such instant and unquestionable demonstration as to defy dispute." Furthermore, as discussed in *In re Zurko*, 57 USPQ 2(nd) 1693, 1695 (Fed. Cir.

2001), when responding to the Board's decision including a rejection in which the Board used official notice to reject the claim, the Court of Appeals stated,

> "We cannot accept these findings by the Board. This assessment of basic knowledge and common sense was not based on any evidence in the record, and therefore, lacks substantial evidence support. As an Administrative Tribunal, the Board clearly has expertise in the subject matter over which it exercises jurisdiction. This expertise may provide sufficient support for conclusions as to peripheral issues. With respect to core factual findings in the determination of patentability, however, the Board cannot simply reach conclusions based upon its own understanding or experience - or on its assessment of what would be basic knowledge or common sense. Rather, the Board must point to some concrete evidence in the record to support of these findings. To hold otherwise would render the process of Appellate Review for substantial evidence on the record a meaningless exercise."

It is submitted that based upon the Final Rejection by the Examiner utilizing "Official Notice", there is no concrete evidence in the record to support the findings of the Examiner. As indicated hereinabove, it appears that the Examiner has merely used hindsight in coming to the conclusion that the Applicant's subject matter recited in claims 22 and 23 and now in claims 1 and 13 respectively was obvious.

There is no question that before the institution of a clearing house such as shown in the Peterson patent, it would be virtually impossible for an insurance company to determine whether a single practitioner billed for more than one treatment during a particular period of time, particularly when the practitioner submitted claims to two different insurance entities. This is true because independent insurance entities would not have the ability to check on the existence of conflicting claims from other insurance companies. The present invention contemplates the use of a clearing house for the purpose of detection fraud by determining whether a single medical practitioner has submitted more than one claim for a single block of treatment time. Claim 1 specifically recites the

use of software to determine the appropriateness of each of the claims submitted by each of a plurality of practitioners based upon whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time on a single day for different patients. Additionally, claim 13 contains a step in which the treatment claims are reviewed to determine the appropriateness of each of those claims including determining whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of time for different patients during a single day.

Even if it was proper to take official notice of the subject matter in cancelled claims 22 and 23, the software required in claim 1 and utilized by the system in claim 13 would have to be drastically altered in the Peterson clearing house. It is imperative that the software utilized by the system and method of the present invention have the ability to check each and every medical practitioner and each and every block of treatment time before each and every claim is completely processed. Therefore, every previous claim submitted by a particular medical practitioner must be retained in a memory and each claim subsequently submitted by that practitioner must be compared to the other claims submitted by that medical practitioner to determine whether that particular medical practitioner has double billed for one treatment block of time. Since it would not be common knowledge to operate a system in this manner, it is respectfully urged that the subject matter recited in claims 1 and 13 and all of the claims depending therefrom are not rendered obvious by the art cited by the Examiner.

Additionally, as indicated hereinabove, the Examiner has supplemented the Advisory Action mailed on December 10, 2003, by a reference to Hartnett-Barry. Although this reference has not been relied upon by the Examiner in affirming his rejection, and not utilized in the rejection, it is still important to note that this article is directed to counteracting uninsured motorist claims and fraud. This article includes various factors of which a claims adjustor might take under consideration when determining

the appropriateness of a motorist's insurance claim. As indicated on page 6 of this article, one of those factors would be "How many examination and treatment rooms are there? Could three insureds really be treated at the same time?" The Hartnett-Barry article does not anticipate or suggest a situation in which medical fraud is to be discovered utilizing the features recited in independent claims 1 and 13. The subject matter in these independent claims recite a system and method in which fraudulent medical claims are automatically determined utilizing the software of the present invention when a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time for different patients. This must be contrasted with the Hartnett-Barry situation in which a manual determination is made as to whether the medical practitioner could conceivably treat more than one patient relating to a single incident. Therefore, even if the Hartnett-Barry was considered by the Examiner, it does appear that this reference does not render the subject matter in claims 1, 13 and all claims depending therefrom obvious. Therefore, it is believed that system claims 1, 2, 6-12 and method claims 13-15 and 19-21 are not obvious in view of the references cited by the Examiner, and that those claims are patentable.

Claim 4 depends directly from system claim 1 and claim 5 depends from dependent claim 4. These claims recite a system in which the appropriateness of each of the claims is based upon the total number of hours submitted by one of the practitioners for a particular duration of time. Claim 5 specifically indicates that this particular duration of time is one work day. Claim 17 is directly dependent upon method claim 13 and claim 18 depends upon claim 17. Similar to the subject matter recited in claims 4 and 5, these claims recite a method in which the appropriateness of each treatment claim is determined based on the total number of hours submitted for a particular duration of time (Claim 17) and wherein that duration of time is a work day (Claim 18). The Examiner rejected both of these sets of claims as being obvious in view of the patents to Peterson and Little as well as the article to Kienle and further in view of U.S.

Patent 6,253,186, issued to Pendleton, Jr. The Examiner has taken the position that the Pendleton, Jr. reference would determine the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time. The Examiner goes on to state that since the Pendleton, Jr. system involves reading provider records from daily claims 158, the particular duration would be one work day.

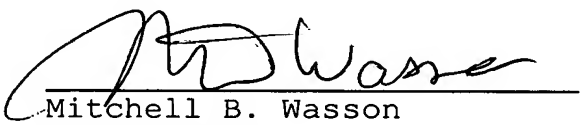
As recited in Col. 9, lines 35-45, the purpose of the Pendleton, Jr. method and apparatus for detecting fraud would be to utilize expert system rules 162 in determining whether a particular provider has submitted claims for numerous and expensive services much greater in number than would be expected for a similar provider. For example, as specifically recited in Col. 9, lines 39-45, "An illustrative example of a situation addressed by expert system rules 162 is the provider who is 'new' to the medicare program (i.e. has just recently begun billing medicare for services), and who submits claims for numerous and expensive services. In this case, the expert system may identify the provider as potentially fraudulent." Additionally, as recited in Col. 9, lines 58-64, "With continued use the system will evolve, through updating and training of the neural network and refinement of the expert system rules, into a sophisticated system capable of distinguishing between innocent variations in claim submission patterns (emphasis added) are reliable providers and potentially fraudulent submissions. Therefore, it is clear that the Pendleton, Jr. patent is not looking at a situation in which the appropriateness of claims submitted by a single practitioner is determined based upon reviewing the claims of a single practitioner to determine whether it was physically possible to bill the amount of hours claimed by that practitioner. In the present invention as recited in claims 4 and 17, the software included in the present invention for determining the appropriateness of each claim, would merely compare the total number of hours billed by a single practitioner in various claims to determine whether it was possible to bill those hours for a particular duration of time. This is in

contradistinction to the teachings of the Pendleton, Jr. patent in which the type of claims generated by a single practitioner would be compared to claims submitted by other practitioners for what would be considered to be normal billing practices in a particular area, be it geographic or the like.

Additionally, it is submitted that the subject matter recited in claims 5 and 18 in which the duration of time is one work day was not recited in the Pendleton, Jr. patent. As indicated by the Examiner, the system in Pendleton, Jr. involves reading a provider record from daily claims 158. This merely means that daily claim sheets are analyzed by the system and not that the system determines the appropriateness of these claims based upon whether the treatment times are greater than the billing hours of one day. Therefore, it is believed that claims 4, 5, 17 and 18 are not obvious in view of the references cited by the Examiner and that these claims are patentable.

In conclusion, it is respectfully submitted that the rejection of claims 1, 2, 4-15 and 17-21 are improper and should be reversed.

Respectfully submitted,



Mitchell B. Wasson
Reg. 27,408

April 14, 2004

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A P P E N D I X

The claims on appeal read as follows:

1. A system for reviewing medical treatment claims provided by a plurality of practitioners to a plurality of insurance entities for the determination of the appropriateness of the medical treatment claims provided to a plurality of patients, comprising:

a clearing house for receiving information from the plurality of practitioners regarding claims to be paid by one or more of the plurality of insurance entities, said clearing house provided with software to determine the appropriateness of each of the claims submitted by each of the plurality of practitioners, wherein said software determines the appropriateness of each of the medical treatment claims based upon whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time on a single day for different patients, said clearing house communicating with the plurality of insurance entities and the plurality of practitioners regarding the appropriateness of each of the claims.

2. The system in accordance with claim 1, wherein said clearing house pays the proper practitioner once said clearing house has determined that a particular claim submitted by that practitioner to said clearing house is appropriate.

4. The system in accordance with claim 1, wherein said software determines the appropriateness of each of the claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time.

5. The system in accordance with claim 4, wherein said particular duration of time is one work day.

6. The system in accordance with claim 1, wherein said clearing house is provided with a memory containing a list of treatment codes and a list of diagnostic codes.

7. The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based reviewing a treatment code with respect to a diagnostic code for a particular patient.

8. The system in accordance with claim 6, wherein said clearing house determines the appropriateness of each claim based upon a determination that a plurality of said treatment codes are mutually exclusive.

9. The system in accordance with claim 2, wherein said clearing house is paid by the appropriate insurance entity when said clearing house pays the proper practitioner.

10. The system in accordance with claim 1, further including a device for entering data provided at each of the practitioner locations.

11. The system in accordance with claim 10, wherein said device includes a bar code reader.

12. The system in accordance with claim 10, wherein said device includes a keyboard.

13. A method of determining the appropriateness of a treatment claim submitted by one of a plurality of practitioners to one of a plurality of insurance entities, the claimed treatment claim covering a treatment prescribed to a patient based upon a particular diagnosis or condition, comprising the steps of:

establishing a clearing house for examining each of the treatment claims;

submitting treatment claims to said clearing house;

reviewing each of the treatment claims to determine the appropriateness of each of the treatment claims, said reviewing step including determining whether a single practitioner has submitted more than one disparate medical treatment claim for a single block of treatment time for different patients during a single day; and

communicating with the appropriate practitioner and the appropriate insurance entity the appropriateness of each of said treatment claims.

14. The method in accordance with claim 13, including the step of having said clearing house pay the practitioner if said reviewing step indicates that a particular submitted treatment claim was appropriate.

15. The method in accordance with claim 14, including the step of having one of the insurance entities pay said clearing house if said reviewing step indicates that a particular submitted treatment claim was appropriate.

17. The method in accordance with claim 13, wherein said reviewing step determines the appropriateness of each treatment claim based upon the total number of claim hours submitted for a particular duration of time.

18. The method in accordance with claim 17, wherein said duration of time is a work day.

19. The method in accordance with claim 13, wherein said reviewing step includes comparing a treatment code included in said treatment claim with a diagnosis code included in said treatment claim.

20. The method in accordance with claim 13, wherein said reviewing step includes comparing more than one treatment code included in said treatment claim with one another.

21. The method in accordance with claim 13, further including the step of obtaining a pre-authorization from one of the insurance entities for the treatment covered by said treatment claim.